



# Benefit Advantage

PO Box 5546 De Pere, WI 54115-5546

Phone (800) 686-6829

Fax (920) 339-0038

E-mail: claims@benadvan.com

Company Name: \_\_\_\_\_

## Qualified Parking Reimbursement Program Request Form

<b>NAME:</b>	Last	First	<b>EMPLOYEE ID:</b>	
<b>ADDRESS:</b>				<b>PHONE:</b> ( )

Please check if this is a new address.

Instructions: Be sure to provide All information requested by this Form. If the form is incomplete, it will be returned to you. Please date and sign the Form, then send it along with your supporting documentation to Benefit Advantage.

Benefit Type Please select one benefit per line	Dates Service Provided	Total of Expense	Proof of Expense Attached	Reimbursement Requested
<input type="checkbox"/> Parking		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
<input type="checkbox"/> Parking		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
<input type="checkbox"/> Parking		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
<input type="checkbox"/> Parking		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
<input type="checkbox"/> Parking		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
<b>Total Reimbursement Requested</b>				\$

\*There is a \$25.00 minimum check amount.

### EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

To the best of my knowledge and belief, my statements on this Form are complete and true. I certify all of the following. I used the Transportation Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Employer. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Transportation Expenses under the Plan. I have not been reimbursed previously for these expenses under The Plan. These expenses have not been reimbursed or are not reimbursable under any other plan. I understand that the expenses reimbursed under the any other plan. I authorized a deduction in my Transportation Account in the amount of the reimbursement.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAX TO (920) 339-0038 OR (920) 339-5736  
OR MAIL TO: BENEFIT ADVANTAGE, INC.  
PO BOX 5546, DE PERE, WI 54115-5546**

